North Central London
Medicines Optimisation Network

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on 20th May 2021

Present:	Prof R Sofat	NCL JFC Chair	(Chair)
	Mr P Gouldstone	NCL CCG, Head of Medicines Management (Enfield)	
	Ms G Smith	RFL, DTC Chair	
	Mr A Dutt	NCL CCG, Head of Medicines Management (Islington)	
	Mr T Dean	Patient Partner	
	Mr S Richardson	WH, Chief Pharmacist	
	Ms W Spicer	RFL, Chief Pharmacist	
	Mr G Purohit	RNOH, Deputy Chief Pharmacist	
	Ms P Taylor	NCL CCG, Head of Medicines Management (Haringey)	
	Dr A Sell	RNOH, DTC Chair	
	Ms R Clark	NCL CCG, Head of Medicines Management (Camden)	
	Mr S Tomlin	GOSH, Chief Pharmacist	
	Ms K Delargy	BEH, Deputy Chief Pharmacist	
	Ms M Singh	NCL CCG, Head of Medicines Management (Barnet)	
In attendance:	Dr P Bodalia	UCLH, Principal Pharmacist	
	Mr A Barron	North London Partners, MEP Project Lead	
	Mr G Grewal	North London Partners, JFC Support Pharmacist	
	Ms M Kassam	North London Partners, JFC Support Pharmacist	
	Ms H Weaver	NHSE, Specialised Commissioning Pharmacist	
	Ms I Samuel	RFL, Formulary Pharmacist	
	Mr F Master	RFL, Formulary Pharmacist	
	Dr A Scourfield	UCLH, Clinical Pharmacologist	
	Dr M George	UCLH, Specialist Registrar Clinical Pharmacology	
	Ms S Amin	UCLH, Formulary Pharmacist	
	Mr S O'Callaghan	UCLH, Formulary Pharmacist	
	Ms S Maru	UCLH, Formulary Pharmacist	
	Ms P McCormick	WH, Specialist Pharmacist	
	Mr S Ta	NEL CSU, Contracting and Commissioning Pharmacist	
	Ms A Sehmi	NMUH, Formulary Pharmacist	
	Ms H Thoong	GOSH, Formulary Pharmacist	
	Mr D Sergian	MEH, Formulary Pharmacist	
	Ms D Joshi	UCLH, Lead Pharmacist	
	Dr J Spillane	NHNN, Consultant Neurologist	
	Dr J Smart	UCLH, Consultant Anaesthetist	
	Dr N Chopra	RFL, Consultant Oncologist	
	Dr E Boleti	RFL, Consultant Oncologist	
	Dr V Talaulikar	UCLH, Associate specialist in Reproductive Medicine	
Apologies:	Dr K Tasopoulos	NMUH, DTC Chair	
	Mr S Semple	MEH, Chief Pharmacist	
	Ms L Reeves	C&I, Chief Pharmacist	
	Dr M Kelsey	WH, DTC Chair	
	Mr A Tufail	MEH, DTC Chair	
	Mr A Shah	RNOH, Chief Pharmacist	

Ms S Stern	NMUH, Chief Pharmacist
Dr S Ishaq	WH, Consultant Anaesthetist
Dr D Burrage	WH, Consultant in Emergency Medicine
Dr R Urquhart	UCLH, Chief Pharmacist

2. Meeting observers

Ms Weaver (NHSE, Specialised Commissioning Pharmacist) and Mr Steven Ta (NEL CSU, Contracting and Commissioning Pharmacist) were welcomed as observers of the meeting.

3. Minutes of the last meeting

The minutes and abbreviated minutes of the 15 April 2021 meeting will be circulated following the meeting.

4. Matters arising

Nil.

5. JFC Outstanding Items & Work Plan

These items were included for information only. Any questions should be directed to Ms Kassam.

6. Members declarations of conflicts of interest

Nil

7. Local DTC recommendations / minutes

7.1 Approved

DTC site	Month	Drug	Indication	JFC outcome
RFL	March 2021	Abrocitinib	EAMS: Patients with severe atopic dermatitis who have not responded or who are ineligible or intolerant to approved treatments	Decision: Added to the NCL Joint Formulary Prescribing: Secondary care Tariff status: N/A Funding: FoC Fact sheet or shared care required: No
BEH	Nov 2021	Guanfancine	Third-line treatment (after stimulants and atomoxetine) of attention deficit hyperactivity disorder in children and adolescents	Decision: Added to the NCL Joint Formulary Prescribing: Referred to the Shared Care Group Tariff status: In tariff Funding: Hospital and CCG Fact sheet or shared care required: NCL ADHD shared care to be updated
MEH	March 2021	Intravitreal bevacizumab	Radiation retinopathy	Decision: MEH only Prescribing: Secondary care Tariff status: In tariff Funding: Hospital Fact sheet or shared care required: No
MEH	April 2021	Chloramphenicol eye drops	Children <2 years of age This has been reviewed following an updated to Summary of Product Characteristics contraindicating use in children < 2 years old	Decision: Added to the NCL Joint Formulary Prescribing: Primary and Secondary care Tariff status: In tariff Funding: Hospital and CCG Fact sheet or shared care required: No Additional information: MEH and NCL CCG to produce a position statement to support GPs

CCG (NPR)	Historic	Pramipexole and Ropinirole	Restless legs syndrome	Decision: Added to the NCL Joint Formulary Prescribing: Primary and Secondary care Tariff status: In tariff Funding: Hospital and CCG Fact sheet or shared care required: No
JFC	March 2021	Sucralfate 2g in 20ml ready to use enema	Radiation proctitis for 6–8-week course (standardisation of product choice)	Decision: Added to the NCL Joint Formulary Prescribing: Secondary care Tariff status: In tariff Funding: Hospital Fact sheet or shared care required: No

8. New Medicine Reviews

8.1 Methoxyflurane (Penthrox®) for use in theatres during dressing changes, line insertion, incision and drainage of abscess and prostate biopsy (Applicant: Dr J Smart, UCLH)

The Committee considered an application to use methoxyflurane in theatres under the supervision of anaesthetists during four minor procedures: vacuum-assisted closure dressing changes, Hickman or Portacath® line insertions, incision & drainage of abscess, or prostate biopsy. Methoxyflurane is licensed for emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain.

There are no RCTs investigating the use of methoxyflurane versus IV sedation, general anaesthesia or spinal anaesthesia.

Gaskell *et al* was a prospective, observational study reporting the effectiveness of inhaled methoxyflurane as an alternative to general anaesthesia or anaesthetist-provided sedation in minor procedures (procedures included dressing changes, incision + drainage of abscess, colonoscopy and removal of brachytherapy rods). Treatment 'success' is defined as one in which the operating conditions were deemed acceptable by the proceduralist, the procedure was completed to the satisfaction of the proceduralist and the analgesia levels delivered were deemed acceptable by the patient. 123 patients underwent 173 procedures, of which 97% were successful. Of the 173 procedures, 69 vacuum-assisted closure dressing changes were completed on 31 patients, 100% were deemed successful. 28 patients underwent abscess incision and drainage, 93% were successful, 2 failed due to insufficient analgesia and were converted to general anaesthesia. The authors noted that local anaesthetic was key to the successful conduct of abscess incision and wound debridement. Adverse events were reported in 7.5%: hypotension (1.7%), cough (1.7%), vomiting (1.2%), oxygen desaturation, nausea, agitation, headache, oversedation (0.6% for all). The key limitations were the lack of comparative data, a small subgroup reflect the proposed cohort, local anaesthesia was used in addition for abscesses and it was unclear how well these patients match the proposed cohort due to the lack of detail in the observational study.

Lee *et al* was a prospective, observational study reporting the effectiveness of methoxyflurane as pain relief during transrectal ultrasound-guided prostate biopsy. Fifteen minutes after the biopsy procedure patients completed a pain score survey using a 10-cm visual analogue scale to separately report pain intensity during pre-biopsy digital rectal examination, ultrasound probe insertion and core biopsy. The median pain scores were 2.0, 2.4 and 3.0 respectively. In 4 cases, methoxyflurane was not tolerated so the patients were converted to periprostatic injection of local anaesthetic (PILA). 46.8% reported that they would be willing to undergo the same procedure using the inhaler again, whereas 14% reported that they would prefer to receive local anaesthetic. The remainder had no preference. Of the 64 patients, 11 had undergone transrectal ultrasound-guided prostate biopsy previously receiving PILA and had pain scores available as a retrospective comparison. In these patients, PILA was significantly better than the methoxyflurane inhaler for pain relief during needle biopsy (median pain score: 2.0 vs 4.0; p= 0.012). The key limitations were the lack of comparative data to general anaesthesia, retrospective comparison showed PILA was superior however PILA is not used in theatres, lastly, these patients were seen in a urology clinic therefore may not be similar to the proposed cohort.

The Committee heard that surgeons will make a clinical decision whether to refer to theatres and this is dependent on many different factors including complications and severity. Procedures may be either day cases or inpatient procedures and the level of sedation that the patient receives is a clinical decision and varies with anaesthetist preference; general anaesthesia, Entonox® and/or IV sedation may be selected. These variables make defining the cohort and comparator difficult.

The Committee heard that methoxyflurane offers benefits to the patient: it avoids the need to fast for 6 hours prior to procedure (as would be required with general anaesthesia), if the procedure is a day case the patient will be discharged quicker, some patients may prefer an inhaled route of administration that avoids needles and allows the patient to regulate their analgesia which avoids over-sedation. Theatres will also benefit from improved efficiency as there is a reduction in need for monitoring and methoxyflurane is easier to administer than IV sedation or general anaesthesia. Observational studies note that due to methoxyflurane's user-dependent nature, a number of drawbacks were observed: patients may adopt incorrect techniques for inhaler use as they are unfamiliar with its use, patients reported a sickly sweet and 'strong fruity' odour which may affect use, anxiety prior to the procedure may further contribute to this, patients may require frequent coaching during the procedure to inhale deeply or frequently enough, sedative effects of methoxyflurane may decrease the patients' ability to correct their technique as instructed.

The Committee heard from Dr Smart that it is unclear which types of patients would be able to use methoxyflurane as an alternative to general anaesthesia/anaesthetist led sedation, therefore methoxyflurane will be used to identify groups of patients that would benefit. Methoxyflurane will be used conservatively initially, patients will be required to fast in case they are converted to general anaesthesia, until sufficient experience is built. Methoxyflurane has not been approved under the NHS elsewhere in London for this indication, however private practice in Royal London reported success when using methoxyflurane for abscess and wound care procedures.

The budget impact is not uncertain as it is not clear which patients will benefit until further experience is available; UCLH, WH and RFL have expressed interest in use. Length of procedure and combination of medications for general anaesthesia vary, however it is estimated to cost ~£20 per patient (this does not account for theatres overheads e.g., tubes, circuits, mask). The cost of one methoxyflurane inhaler is £21.47, depending on the length of the procedure, a maximum of 2 inhalers may be used.

In camera, based on the evidence available and the (i) off-label proposal, (ii) challenges with interpreting observational data in this context [including and not limited to concerns relating to generalisability], (iii) absence RCT data against a relevant comparator, and (iv) less clear cut patient advantages compared to its use in the A&E setting [where methoxyflurane has demonstrated faster resolution of moderate to severe trauma-associated pain, and faster discharge times], the Committee could not recommend the use of methoxyflurane for use in theatres for minor procedures. However, the Committee agreed it was plausible that methoxyfurane was therapeutically beneficial [including potentially avoiding the need for fasting, and shorter theatre times] in some people referred to theatres for minor procedures. Without RCT evidence to support this hypothesis, the Committee agreed it was not appropriate to recommend the use of methoxyflurane outside of a clinical trial setting, the results of which would allow for firmer guidance in the future. An RCT in this setting was considered feasible.

In summary based on the lack of studies assessing a relevant cohort and comparator, the Committee were unable to approve exploratory use outside of a research capacity.

Decision: Not approved

8.2 Melatonin M/R tablets (Slenyto®) and melatonin solution (Colonis 1mg/mL solution): Use in NCL approved indications

The Committee considered a review of melatonin M/R tablets (Slenyto®) and melatonin 1mg/ml solution (manufactured by Colonis Pharma Limited). Both medicines are newly licensed which have the potential to replace use of off-label or unlicensed use of medications for NCL approved indications. Within NCL, newly licensed formulations do not automatically replace unlicensed or off-label use of medicines unless specifically recommended by the Committee as being a cost-effective alternative.

For the Colonis solution, there was no new data to demonstrate efficacy of the licensed product.

For Slenyto, Gringras et al conducted a 13-week, Phase III, placebo-controlled, double-blind study to compare the efficacy and safety of Slenyto and placebo for the treatment of insomnia in patients with Autism Spectrum disorders or Neurogenetic disorders (n=119). Patients were randomised to Slenyto or placebo, initiating at 2mg for three weeks, and escalating to 5mg for the remaining 10 weeks. The primary endpoint, total sleep time (as reported in a sleep and nap diary), was significantly longer with Slenyto compared to placebo (51.16 minutes vs. 18.73 minutes; (difference of 32.43 minutes [95%CI: 2.48 to 62.38 minutes])). Key limitations of the study were the lack of active comparator, relative low number of participants (including four participants with Smith-Magenis syndrome and <4% with sleep maintenance problems), and the lack of objective measurement via actigraphy.

In terms of safety, there is no difference expected in the adverse effects between currently available melatonin formulations and newly licensed formulations. The Colonis solution contains propylene glycol and sorbitol at concentrations that may be unsafe where intake exceeds the threshold of safety based on patient weight; prescribers must be reassured that the excipient quantities per dose are within safety thresholds prior to prescribing.

In terms of budget impact, Slenyto could lead to a budget impact of £219,000 if used instead of the current standard of care (Circadin®) in an estimated population of 700 patients with neurodevelopmental disorders in NCL. There is a risk of prescribing outside of the licensed indications, and if Slenyto replaced all solid oral dosage forms, the total annual budget impact was estimated to be in excess of £2,000,000. When Colonis melatonin solution entered the market in mid-2019, unlicensed 5mg/5mL oral formulations were removed from the Drug Tariff and usage automatically switched over to Colonis melatonin solution; this led to an overall budget impact in excess of £200,000 per annum (a six-fold increase in spend).

The Committee was informed that clinicians in NCL follow JFC recommendations for the use of melatonin therapy (Circadin first-line; crushed Circadin for patients with swallowing difficulties; melatonin solution or suspension for patients with further swallowing difficulties or enteral tubes). Clinicians in NCL have inputted prior to the meeting, and those who have requested Slenyto have requested it to be placed after the patient has attempted all available lines of melatonin therapy. Clinicians do not see the value of Colonis solution over the use of unlicensed products. One unlicensed product used previously in NCL was still available for procurement. The Committee heard from Dr Kriessels that she utilises standard melatonin therapies, and that a majority of patients tolerate Circadin well (either whole or crushed, the latter hidden easily in apple sauce).

In camera, the Committee discussed whether either Slenyto or the Colonis solution added benefit to the Joint Formulary. The Committee recognised that both were licensed products, although neither have demonstrated a proven benefit in efficacy, safety or cost-effectiveness versus existing melatonin formulations. Circadin (either whole or crushed) remains a viable first-line option for the majority of patients in NCL. For patients who cannot tolerate solid dosage forms, a solution or suspension should be used. The Colonis solution does not represent good value for money compared to previously used unlicensed formulations. JFC Support will investigate the current standard of care options used in NCL to identify the most appropriate product to recommend in the NCL melatonin Factsheet.

In summary, based on the lack of evidence available and cost-effectiveness, the Committee could not recommend the use of Slenyto or Colonis Solution.

Decision: Not approved

8.3 FoC scheme: Sotorasib for previously treated $KRAS^{G12C}$-mutated locally advanced or metastatic non-small cell lung cancer (Applicants: Dr N Chopra and Dr E Boleti, RFL)

The Committee considered a free-of-charge (FOC) scheme for sotorasib, a $KRAS^{G12C}$ inhibitor, as second-line treatment for patients with $KRAS^{G12C}$-mutated previously treated non-small cell lung cancer (NSCLC).

CodeBreak 100 was a Phase I, single-arm, open-label study to assess the safety of sotorasib for patients with advanced solid tumours with a $KRAS^{G12C}$ mutation (n=129). Patients were sotorasib at increasing doses up to a maximum of 960mg daily. The primary endpoint was safety; grade III or higher treatment related adverse events occurred in 20.6% of patients, and adverse effects that occurred in at least 3% of patients include increased AST/ALT and diarrhoea. The secondary endpoint, objective response rate, was 35.3% in NSCLC patients who escalated to 960mg sotorasib; disease control (a composite of objective response and stable disease) was 91.2% in NSCLC patients who escalated to 960mg sotorasib. Key

limitations of the study were the study design, relatively low number of NSCLC patients in the study and that it was not designed or powered to demonstrate efficacy.

The phase II portion of the CodeBreak 100 study, a Phase II, single-arm, open-label study to assess the safety and efficacy of sotorasib 960mg in NSCLC patients with a $KRAS^{G12C}$ mutation (n=126) has reported in abstract. The primary endpoint, objective response rate, was 37.4% with sotorasib 960mg daily; disease control was reported as 80.5%. Key limitations include the study design and the results being available in abstract only.

The Committee was informed that a phase III trial of sotorasib 960mg daily versus docetaxel for $KRAS^{G12C}$-mutated NSCLC was underway but no longer recruiting – results have not been reported yet.

By way of comparing sotorasib to docetaxel, the Committee considered the pivotal trial of docetaxel by Shepherd et al for previously treated NSCLC. If similar composites outcomes from the CodeBreak trial were used to report efficacy with docetaxel, the objective response rate would have been reported as 5.5% and disease control reported as 52.8%. This naïve comparison suggests sotorasib may be superior to docetaxel, however does not address treatment effect modifiers that may be different between studies. Further, no data is available on patient orientated outcomes including overall survival and quality of life.

In terms of safety, sotorasib is unlicensed and the manufacturer reports adverse effects to include increased AST/ALT, diarrhoea, nausea, fatigue, abdominal pain and vomiting. It may also interact with cytochrome P450 enzymes and may be affected by P-gp substrates. Periodic liver monitoring is required and up to two dose reductions would be permitted with adverse events. In terms of budget impact, sotorasib is free of charge and the appropriate wording to support ongoing supply for patients has been provided.

The Committee heard from Dr Chopra and Dr Boleti that similar tyrosine kinase inhibitors are currently used in practice, and therefore toxicities are well known and managed. Docetaxel is used frequently as a current second-line therapy for patients with a KRAS mutation. Although difficult to compare, sotorasib demonstrates promise in terms of objective response and toxicity data compared to docetaxel. In terms of healthcare resource utilisation, liver function monitoring would still be given for any second-line therapy; however, if offered instead of docetaxel, there will be a decrease in infusions, bed space occupancy and GCSF (due to the incidence of neutropaenia and neutropaenic sepsis seen with docetaxel in practice).

In camera, the Committee agreed that the Phase III study results would be preferred for decision making. However, the case for early acceptance was strengthened by the availability of Phase II data [abstract only], and by tyrosine kinase inhibitors having similar adverse effect profiles [therefore concerns around the limited safety data for sotorasib were reduced]. Committee acknowledged that there were no ongoing RCTs available for this cohort, so the only access to targeted treatment for this cohort is via the FOC scheme. Given the difference in objective response [naïve comparison] between the pivotal trial for docetaxel versus currently available data for sotorasib, the Committee agreed that sotorasib FOC should be made available.

In summary, the Committee agreed to add sotorasib FOC to the NCL Joint Formulary for previously treated $KRAS^{G12C}$-mutated locally advanced or metastatic NSCLC following standard first-line therapies for advanced squamous NSCLC or non-squamous NSCLC without gene mutation or fusion protein (as per NICE guidance).

Decision: Approved
Prescribing: Secondary care only
Tariff status: N/A
Funding: FOC scheme
Primary and secondary care Fact sheet or shared care required: No

8.4 Estradiol transdermal spray (Lenzetto®) for postmenopausal women requiring transdermal hormone replacement therapy for oestrogen deficiency symptoms (Applicant: Dr V Talaulikar, UCLH)

The Committee considered an application for estradiol transdermal spray (Lenzetto®) for postmenopausal women requiring transdermal hormone replacement therapy (HRT) for oestrogen deficiency symptoms.

Currently oral HRT is offered first-line, transdermal HRT is second line if oral route is cautioned, contraindicated or not tolerated.

Buster *et al* was a 12-week, Phase III, double-blind, placebo-controlled study to assess the efficacy and safety of transdermal estradiol spray in post-menopausal women reporting ≥8 moderate-to-severe hot flushes per day (n=454). Eligible women were randomised to one of the six treatment groups: one, two, or three sprays of estradiol or matching placebo, administered transdermally once daily to the inner forearm. Women with an intact uterus received a daily dose of medroxyprogesterone acetate 5 mg or 10 mg for 2 weeks after the end of the 12-week treatment period. At baseline women experienced ~12 hot flushes per day. The coprimary efficacy endpoints, mean change from baseline in frequency and severity of moderate-to-severe hot flushes at weeks 4 and 12, were statistically significantly reduced with transdermal estradiol compared to placebo (placebo-adjusted treatment effect for hot flush frequency at week 12: -3.34 $p<0.001$, -2.47 $p=0.01$, -3.12 $p<0.001$ for 1-spray, 2-spray, 3 spray respectively). Limitation of this study include lack of comparison to relevant comparator and the majority of participants were white (~70%) with a BMI of 27kg/m^2 which may not be representative of the NCL population.

Fait *et al* was a 24-week uncontrolled open label study to assess the efficacy of Lenzetto on the severity of menopausal symptom using the Menopause Rating Scale (MRS), a validated health related quality of life questionnaire measuring the severity of a range of menopausal symptoms. A significant reduction in the total MRS score between all visits was observed (baseline, week 12 and week 24: 16.5, 9.2, 5.6 respectively, $p<0.001$). The most significant improvement was observed in the areas of 'hot flushes and sweating', 'sexual problems', and 'heart discomfort' (75.4%, 73.2%, and 70.4%, respectively). The lowest improvement was observed for MRS components 'bladder problems', 'depressive mood', and 'anxiety' (51.8%, 58.4%, and 59.4%, respectively). Limitation of this study include the observational nature of the study.

Kovacs *et al* conducted a systematic literature review and analysis to study the efficacy and tolerability of estradiol spray compared to estradiol patches in women with postmenopausal hot flushes. A network meta-analysis was used to compare the effectiveness of estradiol spray to patches (8 RCTs) and application site tolerability was compared descriptively (10 RCTs). In the NMA, all treatments but one (14µg/day patch) resulted in a significantly greater relative reduction in the number of hot flushes than placebo, confidence intervals were large and overlapping. Pairwise comparisons found the 50 mcg/day matrix and 50 mcg/day reservoir patches proved to be the most effective treatment, however this was not statistically significant versus the transdermal spray. The cumulative incidence of local skin reactions with the spray compared favourably to the patches (cumulative incidence with patches vs spray respectively: application site reactions: 1.3% - 54.9% vs 1.3%, erythema: 0% - 47% vs 0.4%, skin irritation: 2.9% - 29% vs 1.3%, itching: 3% - 7% vs 0.4%). The study had a number of key limitations: lack of comparison to estradiol gel, lack of efficacy data reported for menopausal symptoms other than hot flushes, statistical analysis was not carried out for local skin reactions due to heterogeneity of reported outcomes, the NMA included RCTs assessing mild hot flushes – it may not have been appropriate to compare this to Buster *et al* which included only moderate to severe flushes, JFC support identified trials which were not included in the NMA - it was unclear why these were omitted and the study was funded by Gedeon Richter Ltd.

In terms of safety, adverse effects are similar to those experienced with transdermal formulations. The SPC advises women to be counselled on the risk of others coming into contact with the medication applied onto their skin (particularly children) and due to high proportion of ethanol in the formulation women must be advised to avoid fire, flame or smoking until the spray has dried.

In terms of budget impact, Lenzetto® costs between £48 to £145 per annum per patient (dependent if 1 to 3 sprays). Lenzetto® is expected to be more costly than transdermal oestrogen patch (Evorel® 50mcg/day patch costs £50 per patient per annum), similarly costly when Lenzetto® is used in combination with oral progesterone compared to transdermal combination patch (£92 to £189 when used in combination with medroxyprogesterone acetate 10mg, compared to Evorel Conti® costing £169 per patient per annum) and similarly costly to transdermal oestrogen gel (Oestrogel® costs £58 to £115 per patient per annum dependent on 2-4 pumps). The overall budget impact is therefore expected to be -£9000 to £65 000 (depending dose) per year for NCL if used as an alternative to transdermal oestrogen gel.

The Committee heard from Dr Talaulikar that Lenzetto® is proposed as a convenient alternative to estradiol patch or gel. Some patients report issues with the patch such as application site reactions, patch adhesion problems and dislike it's visibility. An alternative on the NCL joint formulary is Oestrogel®; however, some patients find the gel difficult to apply and inconvenient to use. Lenzetto® is quicker to dry than the gel (the SPC for Estrogel® states that it takes 5 minutes to dry, in clinical practice this can be up to 30 minutes), the spray is applied to a smaller area than the gel and the spray does not require hands to spread.

In camera, the Committee heard that oestradiol patches are the most commonly prescribed transdermal HRT and are considered the usual first-line treatment option; this is consistent with patches being the most cost-effective option. The Committee considered the lack of a direct comparison of Lenzetto® to estradiol patches, limitations of the NMA, and likely incremental cost, therefore could not support the use of Lenzetto® as an alternative to estradiol patches in the first-line setting. However, the Committee acknowledged the convenience the spray offers compared to Oestrogel® and were reassured by the improvements reported in the placebo-controlled trial. The Committee supported the use of Lenzetto® as an alternative to estradiol gel in the second-line setting.

Decision: Approved for women requiring topical oestrogen, who are unsuitable for transdermal patches
Prescribing: Primary or secondary care
Tariff status: In tariff
Funding: Trust and CCG
Primary and secondary care Fact sheet or shared care required: No

8.5 Inhaled budesonide for the treatment of COVID-19

In April 2021, the DHSC published a position statement on inhaled budesonide for the treatment of COVID-19 in primary care. The position statement does not recommend inhaled budesonide for a cohort of patients, but does recommend consideration on an individual patient basis. An evaluation was conducted on the available evidence and has been circulated to DTC chairs to establish whether there are any particular patient groups that may benefit from treatment. This will be discussed further offline and a decision brought to the next JFC meeting.

9. Myasthenia gravis pathway

In January 2020, the Committee deferred approval of azathioprine and mycophenolate mofetil for the treatment of myasthenia gravis, and requested a pathway be created for all available therapies. A pathway of treatments for myasthenia gravis was created in collaboration with NHNN and RFL neurologists and specialist pharmacists. The pathway included the position of pyridostigmine, corticosteroids, and steroid-sparing options – including the first-choice of azathioprine and second-choice of mycophenolate. Dr Spillane explained that, once stabilised, patients would require blood test monitoring every two to three months from their GP. The Committee approved the pathway. The NCL DMARDs quick reference guide will be updated with the myasthenia gravis indication to support the transfer of prescribing into primary care.

10. Tadalafil cost reduction

Tadalafil for erectile dysfunction (ED) and nerve-sparing radical prostatectomy (NSRP) was discussed in the November 2014 and January 2015 JFC meetings. In ED, the Committee agreed to hold two PDE5-inhibitors on formulary; sildenafil would be the preferred option, and tadalafil as second-line where patients suffer an idiosyncratic reaction to sildenafil. In terms of post-NSRP, sildenafil used daily (off-label) was preferred for a three-month course offered by secondary care only. At the time of these decisions, generic sildenafil was available however tadalafil was under patent protection and was much more costly. Tadalafil is now off-patent.

ED: JFC Support have received numerous informal requests to position tadalafil 10-20mg PRN as an alternative to sildenafil 25mg-100mg PRN (i.e. to lift the "where patients suffer an idiosyncratic reaction to sildenafil" restriction). The costs for both options are similar (£0.36 to £0.45 per dose for tadalafil, compared to £0.26 to £0.31 per dose of sildenafil).

NSRP: UCLH have expressed an interest to appeal the decision to not recommend daily tadalafil post-NSRP (5mg daily for secondary care only). The cost of a 3 month course of tadalafil is less than for

sildenafil (£4.66 and £8.89 respectively). The Committee heard that NHSE/I guidance 'Items which should not be routinely prescribed in primary care' (2017, updated 2019) recommends against the use of daily tadalafil in primary care however it was noted this guidance pre-date generic tadalafil and does not relate specifically to NSRP.

The Committee agreed that JFC Support should work with the NCL urology network on updating pathways and bring back to the Committee at a future meeting.

11. High-cost drug pathway for moderately to severely active CD

This item was deferred to June JFC meeting

11.1 Ant-TNF for moderately active CD

This item was deferred to June JFC meeting

12. High-cost drug pathway for moderately to severely active UC

This item was deferred to June JFC meeting

13. Next meeting

Thursday 17th June 2021